APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R10 / 11-01)
Approved by State Board of Accounts, 2001

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Application fee
Date fee paid (*month, day, year*)
Receipt number
Application number
License number
License issuance date (*month, day, year*)

Permit fee
Date fee paid (*month, day, year*)
Receipt number
Permit number
Permit issuance date (*month, day, year*)

APPLICANT
Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Check one: ☐ MD ☐ DO	Social Security number *
Address (*number and street or Rural Route*)		
City, state, ZIP code		
Telephone number (*daytime*) ( )	Birthdate (*mo., day, yr.*)	Birthplace
E-mail address		

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?
☐ Yes ☐ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Location	Date of Graduation *(Month, Day, Year)*

EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
(*Please review instruction sheet for address and telephone numbers on how scores may be obtained.*)

☐ FLEX EXAMINATION	☐ STATE BOARD EXAMINATION
☐ Component I ☐ Component II ☐ Other	Examination taken in which state?
☐ NATIONAL BOARD OF MEDICAL EXAMINERS	☐ LMCC EXAMINATION
☐ Part I ☐ Part II ☐ Part III	
☐ USMLE EXAMINATION	☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
☐ Step I ☐ Step II ☐ Step III	☐ Part I ☐ Part II ☐ Part III

PRE-MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED

MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (*Include ALL internships, residencies and / or fellowships*)			
NAME OF PROGRAM	LOCATION	FROM (*month, year*)	TO (*month, year*)

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and diposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☐ No
3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
4. Have you ever been charged with drug addiction?	☐ Yes ☐ No
5. Have you ever been convicted of, plead guilty or *nolo contendere* to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*.)	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed (*month, day, year*)	Signature of applicant